

Hope and Healing of Pinellas

Adult Information Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ e-mail: _____

May we leave messages when calling you? y___ n___

Check here to consent to texting or email to confirm or cancel appointments _____

May we verify your insurance benefits? y___ n___ May we file insurance claims on your behalf? y___ n___

B. Referral: Who can we thank for referring you?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? Yes No

Health Providers:

Are you currently seeking another therapist or psychiatrist?

Therapist name: _____ Phone: _____

Psychiatrist name: _____ Phone: _____

Medications: _____

Mental health diagnosis: _____

Any physical health diagnosis? _____

Employer/Occupation: _____

Education: _____

I. Family-of-origin history:

How would you describe your family while growing up? Relationship with parent(s)?

Describe your relationships with siblings _____

J. Did you experience any physical, emotional or sexual abuse or neglect as a child? y___ n____
Briefly describe_____

Were any of your caregivers addicted? If yes, who and what
substance?_____

Do you have or think you may have a problem with substance use? please
describe_____

Is there a history of mental illness in your family? Please
describe_____

Current relationship status: __single __married __partnered __divorced __separated

Who are your main sources for support?

What are your strengths?

What is your main reason(s) for seeking counseling?

If you have taken part in counseling before, let us know what was helpful, and also not helpful, for
you_____

Thank you for taking the time to complete this form

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.